



## Physician Sponsored Student Application

Complete this application in its entirety. Once complete, you may send your completed Physician Sponsored Student Application, Online Learning Center training transcript, and Hand Hygiene Validation Form in one email to [physiciansponsoredst@baycare.org](mailto:physiciansponsoredst@baycare.org) for processing.

Date

**Incomplete Rotation Requests Will Be Returned**

**Required Field**

### Applicant Information

Last Name  First Name  M.I.   
Street Address  Apartment/Unit#   
City  State  Zip Code   
Phone Number  Email   
Anticipated number of rotation hours:  Rotation Start Date  Rotation End Date   
Your NE Number: NE  Are you a current or previous BayCare team member?  Employee ID: B

### School Information

School Name   
School Contact's First Name  School Contact's Last Name   
Phone Number  Email

### Student Information

What is your Student Type?  MS/PG Year:  Rotation Specialty/Department:

### Facility Location(s) – Select all that apply - Required Field

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> BayCare Surgery Center-Trinity | <input type="checkbox"/> Morton Plant              | <input type="checkbox"/> St. Joseph's – Children's      | <input type="checkbox"/> Winter Haven Behavioral Health |
| <input type="checkbox"/> BayCare Medical Group          | <input type="checkbox"/> Morton Plant North Bay    | <input type="checkbox"/> St. Joseph's – North           | <input type="checkbox"/> Urgent Care Center             |
| Location: <input type="text"/>                          | <input type="checkbox"/> North Bay Recovery Center | <input type="checkbox"/> St. Joseph's – South           | Location: <input type="text"/>                          |
| <input type="checkbox"/> Bardmoor Surgery Center        | <input type="checkbox"/> Physician Surgery Center  | <input type="checkbox"/> St. Joseph's – Women's         | <input type="checkbox"/> Behavioral Health Outpatient   |
| <input type="checkbox"/> Bartow Regional Medical Center | <input type="checkbox"/> South Florida Baptist     | <input type="checkbox"/> St. Joseph's Behavioral Health | Location: <input type="text"/>                          |
| <input type="checkbox"/> Carillon Surgery Center        | <input type="checkbox"/> St. Anthony's             | <input type="checkbox"/> Winter Haven                   | <input type="checkbox"/> Behavioral Health Inpatient    |
| <input type="checkbox"/> Mease Countryside              | <input type="checkbox"/> St. Joseph's              | <input type="checkbox"/> Wesley Chapel                  | Location: <input type="text"/>                          |
| <input type="checkbox"/> Mease Dunedin                  |  |   |   |

### Acknowledgments and Signatures - Required Field

I, \_\_\_\_\_ (Student Name), certify that I am enrolled in the above mentioned school and in good standing. I will work with my school to ensure all Affiliation Agreement required documentation is submitted to my school before the experience begins. I will not complete tasks or procedures independently. I will not complete student hours with non-approved physicians/designees. I will remain with my physician sponsor or designee at all times while in a BayCare facility\* (**Does not apply to Medical Students, Visiting Residents & Fellows**). If I am a current BayCare team member, I will not complete student hours while on the clock as an employee.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician (MD or DO) Sponsor's Name:

☐ BMG/Employed Physician

**By signing, I certify I am an active member of the medical staff and in good standing. I am accountable for the care, treatment, and services provided by this student during their approved rotation. Students I sign this application for will not complete tasks or procedures independently. It is my responsibility as the physician sponsor to notify my insurance carrier. I or my designee will complete any required rotation evaluations.**

Physician (MD or DO) Sponsor Signature: \_\_\_\_\_ Date: \_\_\_\_\_